Washington State Department of Health

Hepatitis B, acute

County

LHJ Use ID _____
☐ Reported to DOH Date ___/___/___
LHJ Classification ☐ Confirmed ☐ Probable
By: ☐ Lab ☐ Clinical ☐ Epi Link: _____

☐ Outbreak-related
*LHJ Cluster#*_____
LHJ Cluster Name: _____
DOH Outbreak # _____

REPORT SOURCE

LHJ notification date ___/___/___
Investigation start date: ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Zip code (school or occupation): _____ Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	**Discrete onset of symptoms**
☐	☐	☐	☐	Diarrhea Maximum # of stools in 24 hours: ____
☐	☐	☐	☐	**Pale stool, dark urine (jaundice)** Onset date ___/___/___
☐	☐	☐	☐	**Abdominal cramps or pain**
☐	☐	☐	☐	**Nausea**
☐	☐	☐	☐	**Vomiting**
☐	☐	☐	☐	**Loss of appetite (anorexia)**
☐	☐	☐	☐	**Fatigue**

Predisposing Conditions

Y	N	DK	NA	
☐	☐	☐	☐	Pregnant Estimated delivery date ___/___/___ OB name, address, phone: _____ _____
☐	☐	☐	☐	History of viral hepatitis, specify type:

	Y	N	DK	NA
Hepatitis A	☐	☐	☐	☐
Hepatitis B	☐	☐	☐	☐
Chronic hepatitis B infection (HBsAg positive > 6 months)	☐	☐	☐	☐
Hepatitis C	☐	☐	☐	☐
Hepatitis D	☐	☐	☐	☐
Other viral hepatitis	☐	☐	☐	☐
Hepatitis of unknown type	☐	☐	☐	☐

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	Perinatal case (newborn)
☐	☐	☐	☐	**Complications, specify:** _____

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy Place of death _____

Vaccinations

Y	N	DK	NA	
☐	☐	☐	☐	Received any doses of hepatitis B vaccine Year of last HBV vaccine dose: _____ Number of doses of HBV vaccine in past: _____ If 3 hepatitis B vaccine doses, titer of HBV antibody test 1-6 mo's from third dose: _____

Laboratory

P = Positive O = Other
N = Negative NT = Not Tested
I = Indeterminate

Collection date ___/___/___
Source _____

P	N	I	O	NT	
☐	☐	☐	☐	☐	**Hepatitis B core antigen IgM (anti-HBc)**
☐	☐	☐	☐	☐	**HBsAg**
☐	☐	☐	☐	☐	**Serum aminotransferase (SGOT [AST] or SGPT [ALT]) elevated above normal**

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

INFECTION TIMELINE

Enter jaundice onset date in heavy box. Count forward and backward to figure probable exposure and contagious periods

	Exposure period		***Contagious period****
Days from onset:	-180	-45	many weeks prior, onset, weeks to years after, onset
Calendar dates:			

** Lifelong if chronic infection*

EXPOSURE (Refer to dates above)

Y N DK NA

- ☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
  Out of: ☐ County ☐ State ☐ Country
  Destinations/Dates: _____
- ☐ ☐ ☐ ☐ Case knows anyone with similar symptoms
- ☐ ☐ ☐ ☐ Contact with confirmed or suspect HBV case
  ☐ Household ☐ Sexual ☐ Needle use
  ☐ Casual contact ☐ Other: _____
- ☐ ☐ ☐ ☐ Congregate living Type:
  ☐ Barracks ☐ Corrections ☐ Long term care
  ☐ Dormitory ☐ Boarding school ☐ Camp
  ☐ Shelter ☐ Other: _____
- ☐ ☐ ☐ ☐ Hospitalized during exposure period
- ☐ ☐ ☐ ☐ Any medical or dental procedure
- ☐ ☐ ☐ ☐ Hemodialysis
- ☐ ☐ ☐ ☐ IV or injection as outpatient
- ☐ ☐ ☐ ☐ Blood transfusion or blood products (e.g. IG, factor concentrates) Date of receipt: __/__/__
- ☐ ☐ ☐ ☐ Organ or tissue transplant recipient, date:__/__/__
- ☐ ☐ ☐ ☐ Dental work or oral surgery
- ☐ ☐ ☐ ☐ Non-oral surgery Type: _____
- ☐ ☐ ☐ ☐ Acupuncture
- ☐ ☐ ☐ ☐ Employed in job with potential for exposure to human blood or body fluids, Job type:
  ☐ Public Safety ☐ Health care (e.g. medical, dental, laundry) ☐ Tattoo or piercing ☐ Other
  Frequency of direct blood or body fluid exposure
  ☐ Frequent (several times weekly)
  ☐ Infrequent ☐ Unknown
- ☐ ☐ ☐ ☐ Accidental parenteral exposure to blood
- ☐ ☐ ☐ ☐ Accidental non-intact skin or mucous membrane exposure to blood
- ☐ ☐ ☐ ☐ Body piercing
  ☐ Home ☐ Commercial ☐ Prison ☐ Unk

Y N DK NA

- ☐ ☐ ☐ ☐ Tattooing
  ☐ Home ☐ Commercial ☐ Prison ☐ Unk
- ☐ ☐ ☐ ☐ Other body modification (e.g. scarification)
- ☐ ☐ ☐ ☐ Shared razor, toothbrushes or nail care items
- ☐ ☐ ☐ ☐ Non-injection street drug use
  Shared equipment non-IDU ☐**Y** ☐**N** ☐**DK** ☐**NA**
- ☐ ☐ ☐ ☐ Injection street drug use, type: _____
- ☐ ☐ ☐ ☐ Shared injection equipment
- ☐ ☐ ☐ ☐ Born outside US
- ☐ ☐ ☐ ☐ Household or sexual contact from endemic country, specify country: _____
- ☐ ☐ ☐ ☐ Any type of sexual contact with others **during exposure period**
  # female sexual partners: _____
  # male sexual partners: _____
  # lifetime total sexual partners: _____
- ☐ ☐ ☐ ☐ Ever diagnosed with an STD
  Treated for STD ☐**Y** ☐**N** ☐**DK** ☐**NA**
  Year of most recent treatment: _____
- ☐ ☐ ☐ ☐ Physical assault on exposed person involving blood or semen
- ☐ ☐ ☐ ☐ Other blood or body fluid exposure
  Other exposure source: _____

How was this person likely exposed to the disease:
☐ Sexual contact ☐ Illicit drugs ☐ Medical/dental procedure
☐ Nonsexual close contact ☐ Other ☐ Unknown
☐ Multiple risk factors

Where did exposure probably occur?
- ☐ U.S. but not WA (State: _____)
- ☐ In WA (County: _____)
- ☐ Not in U.S. (Country/Region: _____)
- ☐ Unknown

Exposure details: _____
_____

- ☐ **No risk factors or exposures could be identified**
- ☐ **Patient could not be interviewed**

PUBLIC HEALTH ISSUES

Y N DK NA

- ☐ ☐ ☐ ☐ Employed as health care worker, if yes: Employed in a job with human blood exposure: ☐ Several times a week ☐ Infrequently ☐ No ☐ Unknown
- ☐ ☐ ☐ ☐ Patient in a dialysis or kidney transplant unit
- ☐ ☐ ☐ ☐ Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset Date: ___/___/___
  Agency and location: _____
  Specify type of donation: _____
- ☐ ☐ ☐ ☐ Failure of vaccine or postexposure prophylaxis

PUBLIC HEALTH ACTIONS

- ☐ Notify blood or tissue bank
- ☐ Prophylaxis of appropriate contacts recommended
  Number recommended prophylaxis: _____
  Number receiving prophylaxis: _____
  Number completing prophylaxis: _____
- ☐ Counseled patient regarding retesting in 3-6 months
- ☐ If case is health care worker performing invasive procedures, advise strict adherence to recommended infection control practices (especially if HBe Ag positive)
- ☐ Retesting during pregnancy recommended
- ☐ Mom counseled about pregnancy risks
- ☐ Investigate vaccine and postexposure prophylaxis failure
- ☐ Other, specify: _____

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____ **Record complete date** ___/___/___

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